canada life™

EVIDENCE OF INSURABILITY

Coverage Detail

Clear | Print

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

- Sections 1-3: To be completed first by the Plan Administrator. Retain a copy of the completed section for your files.
- Section 3: To be reviewed, signed and dated by the employee; including completion of the smoking and beneficiary declarations (if applicable).
- Sections 4-5: To be completed by the employee/spouse and submitted to Canada Life. **Retain a copy for your files.**
- Employee to send the form directly to Canada Life.

Section #1 Employee's Information *Completed by Plan Administrator*

Name of Group Policyholder (Employer)	Policy No.	Division No.	Benefit Class

Employee Last Name	First Name	Middle Initial	ID No.

Date of Employment MMM/DD/YYYY	Annual Earnings	Plan Administrator's Name	Plan Administrator's Phone No. XXX-XXX-XXXX	Plan Administrator's Email Address

Is the employee currently actively at work? ☐ Yes ☐ No

If no, please indicate reason and Expected Return to Work Date. MMM/DD/YYYY

☐ Maternity/Paternity ☐ On Claim / Personal LOA / Other

Plan Administrator's Authorization

☐ I hereby certify that the information on this Coverage Detail form is accurate.

Date Authorized MMM/DD/YYYY

Section #2 Reason for Application *Completed by Plan Administrator*

☐ New Enrolment

☐ *Late Applicant (Eligibility Period Expired) . . . . . Complete section 3 (A) . . . . . ▶ *Application for Group Coverage, or Group Coverage Change Form, must be included.

☐ Increase Coverage . . . . . Complete applicable portion of Section 3 (B), (C) or (D)

☐ Annual Enrolment - Effective Date: MMM/DD/YYYY . . . . . Complete applicable portion of Section 3 (B), (C) or (D)

Section #3 Benefits Requested *Completed by Plan Administrator*

Section #3 (A) For Late Applicants

	Employee	Spouse	Children
Basic Life	☐	☐	☐
Healthcare	☐	☐	☐
***Dental**	☐	☐	☐
Short Term Disability	☐		
Long Term Disability	☐		

▶ *Dental Restrictions may apply. Refer to employee booklet or contract.

Section #3 (B) Excess Coverage

		Current Amount	New Total Amount Applied For
Life	☐ Basic ☐ Supplemental		
Short Term Disability			
Long Term Disability			

Section #3 (C) Optional Flex Benefits

	Current: % of earnings	Current Amount ($)	New Option: % of earnings	New Amount ($)
Short Term Disability				
Long Term Disability				

M5995-1/20

Section #3 Benefits Requested *...continued*

Section #3 (D) Optional Coverage

New employees and their spouses may elect, without evidence, within 31 days of eligibility, Optional Critical Illness Insurance up to the Non-Evidence Maximum (NEM) amount for their group plan. The NEM must be confirmed by plan administrator. (Step 3 below).

Applicant	(1) Current Amount	(2) New Total Amount Applied for	**(3) Amount Available without Evidence (NEM)** (Confirm with Plan Administrator)	(4) Amount Applied for with Medical Evidence (Steps 2-3)	If plan is % of salary, total % applied for:
Employee					
Optional Life					
Optional Critical Illness					
Spouse					
Optional Life					
Optional Critical Illness					
Child					
Optional Life					

****Medical questionnaire not required if applying for the NEM amount.** Overall maximum for optional critical illness insurance is $250,000.

Smoking Declaration *Completed by Member*

Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form?

	YES	NO
EMPLOYEE	☐	☐
SPOUSE	☐	☐

Optional Life Beneficiary Designation *Completed by Member*

This section must be completed to designate a beneficiary for your life benefits, if applicable. **The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed. Please print clearly, in INK.**

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

First Name	Last Name	Middle Initial	Percent allocated	Relationship to employee

To be divided as follows: ☐ As per the percentage indicated above, or ☐ In equal shares to the survivor(s)

▶ The Beneficiary for the spousal or child coverage shall be the employee if living, otherwise the estate. I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

NOTE: Where Quebec law applies: and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked “Revocable”, below.

I hereby make the above beneficiary designation: ☐ Revocable, I may change this beneficiary at any time

▶ An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without consent of the revocable beneficiary.

Plan Member’s Signature

Signature	Date
	MMM/DD/YYYY

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EVIDENCE OF INSURABILITY

Applicant Information

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Section #4 Member and Dependant Details *Completed by the Member*

Employee Information

Name of Group Policyholder (Employer) | Policy No.

Employee Last Name | First Name | Middle Initial | Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Date of Birth MMM/DD/YYYY | Occupation | Job Duties

Home Mailing Address | Street | City | Province | Postal Code

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number XXX-XXX-XXXX | Best time to call ☐ Day ☐ Evening | Alternate Contact Number XXX-XXX-XXXX | Extension XXXX | Best time to call ☐ Day ☐ Evening

Spouse Information (if applicable) - *only required if you are applying for dependant coverage.*

Spouse Last Name | First Name | Middle Initial | Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other

Date of Birth MMM/DD/YYYY | Occupation | Job Duties

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number XXX-XXX-XXXX | Best time to call ☐ Day ☐ Evening | Alternate Contact Number XXX-XXX-XXXX | Extension XXXX | Best time to call ☐ Day ☐ Evening

Child Information (if applicable) - *only required if you are applying for dependant coverage.*

	Child Last Name	Child First Name	Gender	Date of Birth
Child (1)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY
Child (2)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY
Child (3)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY
Child (4)			☐ Male ☐ Female ☐ Undisclosed ☐ Other	MMM/DD/YYYY

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EVIDENCE OF INSURABILITY

Medical & Lifestyle Questionnaire

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

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- Section 3: To be reviewed, signed and dated by the employee; including completion of the smoking and beneficiary declarations (if applicable).
- Sections 4-5: To be completed by the employee/spouse and submitted to Canada Life. **Retain a copy for your files.**
- Employee to send the form directly to Canada Life.

YOU SHOULD NOT TELL US ABOUT ANY GENETIC TEST WHICH YOU MAY HAVE HAD DONE. YOU MUST HOWEVER, TELL US IF YOU ARE HAVING TREATMENT FOR, OR EXPERIENCING SYMPTOMS OF A GENETIC CONDITION.

Section #5 Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

EE = Employee **SP** = Spouse **CH** = Child(ren)

1. Do you now have or have you ever had: cancer, heart disease, diabetes, arthritis, any neurological, psychiatric, intestinal or respiratory disorders, or any other chronic medical condition(s)?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe medical condition, including the date of onset and duration.
2. Have you ever tested positive for hepatitis or HIV?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe which test, why you had it and when.
3. Have you ever had an MRI or CT scan?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year, describe for what reason(s) and the results.
4. Have you ever stayed overnight in a hospital?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide the approximate date that you left work, duration off work and medical condition.
6. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 5?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide date and describe the medical condition, if not already described above.
7. Have you ever had an application for insurance declined or modified?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year and describe for what reason(s).
8. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe the reason.
9. In the last 12 months have you been taking any prescription medication?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
10. Have you ever been advised to drink less alcohol by your physician, or used drugs (including marijuana) for non-medical reasons in the last 10 years?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide details of when, which product used, and frequency of use per week.
11. Do you drink alcohol?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide type of alcohol and quantity per week.
12. Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco, or nicotine products in any other form?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide which product you use, how much/many per day.

Section #5 Personal Medical History and Lifestyle Information *...continued*

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 7 - Additional Details at the end of this document and provide the number of the question.**

EE = Employee **SP** = Spouse **CH** = Child(ren)

13. Have you gained or lost more than 10 pounds in the last 12 months?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please specify weight loss or gain, amount of change in weight, and reason.
14. Current height and weight: EMPLOYEE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds		
15. Do you have a regular healthcare provider? If yes, please advise (in section to the right) Provider's name, address and date and reason of last appointment.	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	
16. Have you been referred to any medical specialists in the last 2 years?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide the name of specialist, type of specialty and medical reason for visit.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	Yes No EE ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe the type and frequency of the activity.
18. Please describe weekly exercise including type of activity, duration and frequency.		

Family History

19. For each applicant, do your parents, siblings, spouse or children suffer or have suffered from any of the following:

- Alzheimer's Disease
- Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer
- Cardiomyopathy
- Dementia
- Diabetes
- Heart Disease
- Huntington's chorea
- Motor Neuron disease
- Multiple Sclerosis
- Parkinson's Disease
- Polycystic Kidney disease
- Retinitis Pigmentosa
- Stroke
- and/or any other hereditary medical condition

▶ **Employee:** ☐ **Yes** ☐ **No** ▶ **Spouse:** ☐ **Yes** ☐ **No** ▶ **Children:** ☐ **Yes** ☐ **No**

If yes, please complete the appropriate section below. Use extra paper if required.

Employee (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Please provide any additional information that you feel is important:

Notice About MIB Inc.

IMPORTANT NOTICE

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to the MIB Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance or submit a claim for benefits to such a company, the bureau will upon request supply the company with the information it may have.

Canada Life or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the bureau the action taken on the basis of your current request for insurance.

If you wish to see the information in your bureau file or have it corrected, please contact the bureau's information office at:

Suite 501, 330 University Avenue, Toronto ON M5G 1R7, Tel 416.597.0590

Protecting Your Personal Information

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship.*The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.*

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Authorization and Declarations

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan;
- Canada Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application;
- Canada Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Canada Life to communicate with me about this application using the email address I have provided;
- My plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I am actively at work on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- I have retained a copy of this application;
- If applying for coverage for dependents, I am authorized to act on their behalf;
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the effective date of any coverage approved by Canada Life must be reported to Canada Life. I understand that if I fail to do so, any coverage granted may be void.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be void. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of Canada Life, I am not insurable for all or part of that benefit.

For Quebec Applicants: I request that all communication and documents be in English.
Je demande à ce que toutes les communications et tous les documents soient en anglais.

Employee Signature _____ Date Signed _____
MMM/DD/YYYY

Spouse Signature _____ Date Signed _____
MMM/DD/YYYY

Mailing Address

Clear Print

The Canada Life Assurance Company
Group Medical Underwriting
PO Box 6000
Winnipeg MB R3C 3A5

Email: groupmed@canadalife.com
TTY Line 1.800.990.6654 (available for the deaf or hard of hearing)

Additional Details

This page is to be used if you require **extra space to respond to a question.**
Provide the number of the question you are addressing.

EE = Employee **SP** = Spouse
CH = Child(ren)

Question #	Details